PLAN YEAR

2024

JAN. 1-DEC. 31, 2024

EMPLOYEE BENEFIT

ENROLLMENT GUIDE

HEALTH | DENTAL | LIFE | VISION

OKLAHOMA
Office of Management
& Enterprise Services

Biweekly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2024

Biweekly Benefit Allowances	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	$ 362.79	$ 682.90	$ 802.50	$ 879.13	$ 490.99	$ 580.33

Biweekly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 300.39	$ 713.38	$ 991.83	$ 1362.92	$ 578.84	$ 949.93
CommunityCare HMO	$ 325.03	$ 706.11	$ 869.60	$ 983.55	$ 488.52	$ 602.47
GlobalHealth HMO	$ 489.71	$ 1212.57	$ 1492.22	$ 1669.26	$ 769.36	$ 946.40
HealthChoice High and High Alternative	$ 339.81	$ 738.21	$ 909.14	$ 1028.26	$ 510.74	$ 629.86
HealthChoice Basic and Basic Alternative	$ 271.54	$ 590.20	$ 730.23	$ 827.06	$ 411.57	$ 508.40
HealthChoice High Deductible Health Plan (HDHP)	$ 236.84	$ 514.96	$ 637.29	$ 721.49	$ 359.17	$ 443.37
TRICARE Supplement – Selman & Company	$ 32.75	$ 64.75	$ 90.50	$ 90.50	$ 64.75	$ 90.50

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 17.54	$ 35.08	$ 49.30	$ 71.34	$ 31.76	$ 53.80
BCBSOK – BlueCare Dental Low Plan	$ 11.92	$ 23.84	$ 34.14	$ 49.04	$ 22.22	$ 37.12
Cigna Prepaid High (K1I09)	$ 6.78	$ 12.27	$ 16.47	$ 19.49	$ 10.98	$ 14.00
Cigna Prepaid Low (OKIV9)	$ 5.24	$ 8.64	$ 10.95	$ 13.85	$ 7.55	$ 10.45
Delta Dental PPO	$ 19.85	$ 39.70	$ 56.97	$ 83.35	$ 37.12	$ 63.50
Delta Dental PPO – Choice	$ 8.94	$ 29.19	$ 49.59	$ 78.70	$ 29.34	$ 58.45
HealthChoice Dental	$ 24.29	$ 48.58	$ 68.22	$ 98.95	$ 43.93	$ 74.66
MetLife High Classic MAC	$ 25.45	$ 50.90	$ 72.71	$ 104.89	$ 47.26	$ 79.44
MetLife Low Classic MAC	$ 14.45	$ 28.90	$ 41.29	$ 59.37	$ 26.84	$ 44.92
Sun Life Preferred Active PPO	$ 17.49	$ 34.89	$ 47.95	$ 69.96	$ 30.55	$ 52.56

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 5.20	$ 9.84	$ 14.44	$ 15.59	$ 9.80	$ 10.95
Superior Vision	$ 3.70	$ 7.37	$ 10.85	$ 14.52	$ 7.18	$ 10.85
Vision Care Direct	$ 7.74	$ 13.22	$ 18.70	$ 25.46	$ 13.22	$ 19.98
VSP (Vision Service Plan)	$ 4.31	$ 7.14	$ 9.93	$ 13.25	$ 7.10	$ 10.42

DISABILITY	$5.18	
LIFE	Basic Life ($20,000) $2.60	First $20,000 of Supplemental Life $2.60

SUPPLEMENTAL LIFE – Age-rated cost per additional $20,000 unit			
<30 – $0.60	30-34 – $0.60	35-39 – $0.60	40-44 – $0.80
45-49 – $1.40	50-54 – $2.60	55-59 – $4.00	60-64 – $4.60
65-69 – $7.40	70-74 – $12.80	75+ – $19.60	

DEPENDENT LIFE	Low Option $1.30	Standard Option $2.16	Premier Option $5.63

Monthly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2024

Monthly Benefit Allowances	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	$ 725.58	$ 1,365.80	$ 1,605.00	$ 1,758.26	$ 981.98	$ 1,160.66

Monthly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 600.78	$ 1426.76	$ 1983.66	$ 2725.84	$ 1157.68	$ 1899.86
CommunityCare HMO	$ 650.06	$ 1412.22	$ 1739.20	$ 1967.10	$ 977.04	$ 1204.94
GlobalHealth HMO	$ 979.42	$ 2425.14	$ 2984.44	$ 3338.52	$ 1538.72	$ 1892.80
HealthChoice High and High Alternative	$ 679.62	$ 1476.42	$ 1818.28	$ 2056.52	$ 1021.48	$ 1259.72
HealthChoice Basic and Basic Alternative	$ 543.08	$ 1180.40	$ 1460.46	$ 1654.12	$ 823.14	$ 1016.80
HealthChoice High Deductible Health Plan (HDHP)	$ 473.68	$ 1029.92	$ 1274.58	$ 1442.98	$ 718.34	$ 886.74
TRICARE Supplement – Selman & Company	$ 65.50	$ 129.50	$ 181.00	$ 181.00	$ 129.50	$ 181.00

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 35.08	$ 70.16	$ 98.60	$ 142.68	$ 63.52	$ 107.60
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 47.68	$ 68.28	$ 98.08	$ 44.44	$ 74.24
Cigna Prepaid High (K1I09)	$ 13.56	$ 24.54	$ 32.94	$ 38.98	$ 21.96	$ 28.00
Cigna Prepaid Low (OKIV9)	$ 10.48	$ 17.28	$ 21.90	$ 27.70	$ 15.10	$ 20.90
Delta Dental PPO	$ 39.70	$ 79.40	$ 113.94	$ 166.70	$ 74.24	$ 127.00
Delta Dental PPO – Choice	$ 17.88	$ 58.38	$ 99.18	$ 157.40	$ 58.68	$ 116.90
HealthChoice Dental	$ 48.58	$ 97.16	$ 136.44	$ 197.90	$ 87.86	$ 149.32
MetLife High Classic MAC	$ 50.90	$ 101.80	$ 145.42	$ 209.78	$ 94.52	$ 158.88
MetLife Low Classic MAC	$ 28.90	$ 57.80	$ 82.58	$ 118.74	$ 53.68	$ 89.84
Sun Life Preferred Active PPO	$ 34.98	$ 69.78	$ 95.90	$ 139.92	$ 61.10	$ 105.12

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 10.40	$ 19.68	$ 28.88	$ 31.18	$ 19.60	$ 21.90
Superior Vision	$ 7.40	$ 14.74	$ 21.70	$ 29.04	$ 14.36	$ 21.70
Vision Care Direct	$ 15.48	$ 26.44	$ 37.40	$ 50.92	$ 26.44	$ 39.96
VSP (Vision Service Plan)	$ 8.62	$ 14.28	$ 19.86	$ 26.50	$ 14.20	$ 20.84

DISABILITY	$10.36	
LIFE	Basic Life ($20,000) $5.20	First $20,000 of Supplemental Life $5.20

SUPPLEMENTAL LIFE – Age-rated cost per additional $20,000 unit

<30 – $1.20	30-34 – $1.20	35-39 – $1.20	40-44 – $1.60
45-49 – $2.80	50-54 – $5.20	55-59 – $8.00	60-64 – $9.20
65-69 – $14.80	70-74 – $25.60	75+ – $39.20	

DEPENDENT LIFE	Low Option $2.60	Standard Option $4.32	Premier Option $11.26

Terms for understanding your insurance

Deductible: The out-of-pocket amount you pay before insurance pays expenses. Many plans provide certain coverages before deductible. Refer to plan for specifics.

Premium: The amount you pay for insurance each pay period.

Copay: A fixed out-of-pocket amount you pay for covered services.

Coinsurance: A percentage of costs you pay after your deductible is met.

Primary care physician (PCP): A physician you choose who provides both first contact and a continuing care for a variety of medical conditions. Some HMOs require a PCP referral for other services.

Out-of-pocket maximum: A predetermined amount a covered individual must reach before insurance pays 100% of eligible medical expenses.

Explanation of benefits (EOB): A statement provided by your health insurance company explaining how medical treatments and services were paid.

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TABLE OF CONTENTS

Administrative Rules of the Office of Management and Enterprise Services. The rules of the Oklahoma Administrative Code, Title 260, are controlling in all aspects of plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of any plan.

A fully accessible version of this guide is available at **Oklahoma.gov/omes**. Select Services, then Employees Group Insurance Division.

2024 PLAN CHANGES

Below is a summary of significant plan changes. Details of changes can be found in the comparison of benefits charts and are indicated by **bold** text.

Most plans have premium changes. Please refer to the monthly premiums at the beginning of this guide.

HEALTH PLANS

Blue Cross Blue Shield of Oklahoma

- The BlueLincs HMO drug formulary has changed to the BCBSOK Performance Drug List.

CommunityCare

- The CommunityCare HMO plan has had a significant increase in service areas.

DENTAL PLANS

Sun Life Preferred Active PPO

- The non-network orthodontic care lifetime maximum has decreased to $1,500.
- The plan year maximum has decreased to $1,750.

VISION PLANS

- There are no significant plan changes among the vision plans.

GENERAL INFORMATION

The benefits you select will take effect Jan. 1 — or for new employees, the effective date of your coverage — through Dec. 31, 2024, or the last day of the month of your termination date.

After enrollment, the plans you select may provide more information about your benefits. Contact each plan directly if you have questions about your benefits. Refer to Contact Information at the back of this guide.

It is your responsibility to review your benefits and know what is covered before choosing your benefits.

Enrollment in a plan does not guarantee a provider will remain in your plan's network for the entire year. You enroll with the plan and not the provider. If your provider terminates their contract during the plan year, this does not allow you to change your plan carrier.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you are covered under two insurance plans, one primary and one secondary. Most insurance plans require you to annually verify if you or any of your covered dependents have other health or dental insurance. Failure to verify other insurance

coverage may result in denial of claims until verification is completed. You may complete your verification by contacting the plan directly. Refer to Contact Information at the back of this guide.

HEALTH PLANS

There are several health plans available:

- BCBSOK – BlueLincs HMO.
- CommunityCare HMO.
- GlobalHealth HMO.
- HealthChoice High and High Alternative.
- HealthChoice Basic and Basic Alternative.
- HealthChoice HDHP.
- TRICARE Supplement Plan.

Refer to Comparison of Network Benefits for Health Plans on Pages 20-31 for benefit information.

- Includes standard plan provisions only. For all plan benefits and limitations, contact each plan. Refer to Contact Information at the back of this guide.
- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- All health plans coordinate benefits with other group insurance plans you have in force.
- If you select an HMO:
  - **You must live or work within an HMO's ZIP code service area to be eligible.** Post office box addresses cannot be used to determine your HMO eligibility. Refer to **Pages 15-19** for the HMO ZIP Code Lists.
  - You must use the provider network designated by that plan for Oklahoma.

Electing a TRICARE Supplement Plan (military only)

NOTE: If you do not currently have TRICARE coverage as a current or former military member, you are not eligible for the TRICARE Supplement Plan. If you currently have TRICARE coverage and are younger than age 65, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. **You will be required to Opt-out of the Basic Plan, which means you will be opting out of Health, Dental, Life Insurance, Disability, Supplemental Life Insurance and Dependent Life Insurance.** The plan covers the cost shares and copays, including prescription drugs, a portion of the TRICARE deductible, and excess charges up to the legal limit. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement Plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare. For more information on the TRICARE Supplement Plan, refer to **oklahoma.gov/omes/services/employees-group-insurance-division/tricare-supplement**.

Note: Residents of WA, CO, UT, AK, NH, OR, ME and PR are not eligible to participate in the TRICARE Supplement Plan.

DENTAL PLANS

There are several dental plans available:

- BCBSOK – BlueCare Dental High Plan.
- BCBSOK – BlueCare Dental Low Plan.
- Cigna Prepaid High (K1I09).
- Cigna Prepaid Low (OKIV9).
- Delta Dental PPO.
- Delta Dental PPO – Choice.
- HealthChoice Dental.
- MetLife High Classic MAC.
- MetLife Low Classic MAC.
- Sun Life Preferred Active PPO.

Refer to Comparison of Benefits for Dental Plans on Pages 32-39 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- Some plans may not be available in all areas.

VISION PLANS

There are several vision plans available:

- Primary Vision Care Services.
- Superior Vision.
- Vision Care Direct.
- VSP.

Refer to Comparison of Benefits for Vision Plans on Pages 40-44 for benefit information.

- Verify your vision provider participates in a vision plan's network by contacting the plan, visiting the plan's website or calling your provider.
- All vision plans have limited coverage for services provided by non-network providers.

If your provider leaves your health, dental or vision plan, you cannot change plans until the next annual Option Period. However, you can change providers within your plan's network as needed.

HEALTHCHOICE HEALTH PLANS

Tobacco-Free Attestation for HealthChoice High or Basic

If you are enrolled in the HealthChoice High or Basic plan and wish to stay enrolled in that plan, you must complete the HealthChoice Tobacco-Free Attestation for Plan Year 2024 by Nov. 10, 2023. This does not apply to members who are enrolling in the HDHP plan. However, if you are currently enrolled in the HealthChoice HDHP plan and wish to enroll in the High or Basic plan for the next year, you will need to complete the HealthChoice Tobacco-Free Attestation. The online Tobacco-Free Attestation for Plan Year 2024 is open Sept. 4 through Nov. 10, 2023. HealthChoice members who are tobacco free can update their Tobacco-Free Attestation online in just a few minutes.

The attestation is waived for the first year of enrollment in the High or Basic plan but is required each year thereafter to remain enrolled. If you are in the process of quitting tobacco, you must be tobacco free for 90 days prior to the deadline to attest to being tobacco free.

If you cannot sign the Tobacco-Free Attestation because either you or a covered dependent uses tobacco, you can still qualify for the High or Basic plan if those who use tobacco complete one of the following alternatives by Nov. 10:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline (800-QUIT-NOW) and Optum and completing three coaching calls.
- Provide a letter from your doctor indicating it is not medically advisable for you or your covered dependents to quit tobacco.

If you do not complete the Tobacco-Free Attestation or complete one of the reasonable alternatives, and you are not in the first-year grace period, you will automatically be moved to one of the alternative plans that correspond to your current plan effective Jan. 1, and your annual deductible will be higher. You also have the option of enrolling in the HDHP plan which does not require the Tobacco-Free Attestation. Refer to the Comparison of Network Benefits for Health Plans.

Health savings account information for HealthChoice HDHP

Plan Year 2024 HSA contribution limits and catch-up amounts

Employee only: $4,150; catch up (age 55 or older) + $1,000

Family: $8,300; catch up (age 55 or older) + $1,000

HSAs for HealthChoice HDHP members allow you to save money for HSA-eligible expenses and give you the ability to take greater control of your own health care costs. An HSA allows you to have pretax HSA contributions withheld from your paycheck.

HealthChoice contracts with American Fidelity Health Services Administration to waive fees and make establishing and keeping an HSA easier and more convenient. For more information about HSAs, contact American Fidelity at the number listed in Contact Information at the back of this guide.

There is no requirement to use American Fidelity. Members may choose any HSA administrator; however, to have pretax contributions withheld from your paycheck, you must contact your benefit partner for more information.

If you choose American Fidelity for your HSA, you must complete the American Fidelity Health Savings Account Form and return it directly to American Fidelity. Please contact your benefit partner to request a form.

NOTE: A member cannot contribute to both an HSA and a Section 125 flexible spending account at the same time. Some exceptions may apply for dependent care FSAs.

Triple tax savings advantage

When coupled with your Section 125 plan, the HSA allows you a triple tax advantage:

- Pretax contributions.
- Tax-free interest accumulation.
- Tax-free distributions for qualified medical expenses.

HSA card

Use your HSA card to pay for eligible expenses instead of paying out of pocket.

- Direct access to funds.
- Eliminates distribution wait time.
- Accepted at doctor's offices, retailers and pharmacies.

Online account access

Distributions can be requested online either before or after an expense has been incurred. Distributions can be received via check by mail or by direct deposit.

HEALTHCHOICE LIFE INSURANCE PLAN

- As a new employee, you can elect life insurance coverage within 30 days of your employment or initial eligibility date. You can enroll in Guaranteed Issue, in addition to Basic Life, without a life insurance application. Guaranteed Issue is two times your annual salary rounded up to the nearest $20,000. All requests for supplemental coverage above Guaranteed Issue require you to submit a life insurance application for approval.
- As a current employee, if you did not enroll in life coverage when first eligible, you can submit a life insurance application for approval to enroll:
  - During the annual Option Period (enroll in or increase life coverage).
  - Within 30 days of a midyear qualifying event, such as birth of a child or marriage.
- The window to complete and submit a life insurance application during Option Period is Sept. 18-Oct. 31, 2023. Contact your benefit partner for a life insurance application. Completed applications must be submitted directly to EGID by fax or mail.

As a current employee, you can also enroll in life insurance coverage within 30 days of the loss of other group life coverage. You are eligible to enroll in the amount of coverage you lost

rounded up to the next $20,000 unit without submitting a life insurance application for approval. Proof of the loss of the other coverage is required.

Basic Life insurance: For you

- Basic Life pays a benefit of $20,000 to your beneficiary in the event of your death.
- Basic Life includes Accidental Death and Dismemberment benefits, which pays an additional $20,000 to your beneficiary if your death is due to an accident. It also pays benefits if you lose your sight or a limb due to an accident.

Supplemental Life insurance: For you

- You can enroll in Supplemental Life in units of $20,000. The maximum amount of Supplemental Life coverage available is $500,000, for a total amount of $520,000 in life insurance coverage. You must complete and submit a life insurance application, which must be approved before coverage begins.
- The first $20,000 of Supplemental Life provides an additional $20,000 of AD&D benefits.

Beneficiary designation

For Basic Life and Supplemental Life benefits, you must name your beneficiaries when you enroll. Your designation can be changed at any time. Contact your benefit partner for a Beneficiary Designation Form or more information. This form is also available at **HealthChoiceOK.com** under Member Forms. Life insurance benefits are paid according to the information on file.

Dependent Life insurance: For your eligible dependents

- If you are enrolled in Basic Life, you can elect Dependent Life for your spouse and other eligible dependents during your initial enrollment, the annual Option Period, within 30 days of the loss of other group life insurance or other midyear qualifying event without a life insurance application. There is no beneficiary designation for Dependent Life. Any Dependent Life proceeds are paid directly to the member.
- Each eligible dependent must be enrolled in Dependent Life. Regardless of the number of dependents covered, the monthly premium is a flat amount. Benefits are paid only to the member. Below are the three levels of coverage:

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
Spouse	$ 6,000 of coverage	$ 10,000 of coverage	$ 20,000 of coverage
Per covered child up to age 26	$ 3,000 of coverage	$ 5,000 of coverage	$ 10,000 of coverage

Dependent Life does not include AD&D benefits.

HEALTHCHOICE DISABILITY PLAN

The HealthChoice Disability Plan provides partial replacement income if you are unable to work due to an illness or injury. Disability coverage is not available to dependents.

Eligibility

Enrollment in the disability plan is effective the first day of the month following your employment date or the date you become eligible with your employer. You become eligible for disability benefits once you have been actively at work for 31 consecutive days after the effective date of coverage. During that time, you must continuously perform all material duties of your regular occupation. Any claim for disability benefits must be filed within one year of the date your disability began. Contact your benefit partner for more information.

For further details, refer to the HealthChoice Disability Handbook.

ENROLLMENT PERIODS

Option Period enrollment: Coverage effective Jan. 1, 2024

This is when eligible employees can:

- Enroll in coverage.
- Change plans or drop coverage.
- Increase or decrease life coverage.
- Add or drop eligible dependents from coverage.

You can enroll in health, dental, life and/or vision coverage for yourself and/or your dependents during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage within the past 12 months without a midyear qualifying event, you cannot reinstate that coverage for at least 12 months.

Initial enrollment: Coverage effective the first of the month following your employment date or the date set by your employer

This is when new employees are eligible to:

- Enroll in coverage.
- Enroll eligible dependents.
- Submit a life insurance application for review and approval for life insurance coverage above Guaranteed Issue.

As a new employee, you have 30 days from your employment or eligibility date to enroll in coverage. Check with your benefits partner for more information.

You have 30 days following your eligibility date to make changes to your original enrollment.

HIPAA special enrollment rights: Coverage generally effective the first of the month following a qualifying event

If you are declining enrollment for yourself or your dependents (including your spouse) because of other qualified health insurance or group health plan coverage, you may be able

to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after other coverage for you or your dependents ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefit partner.

Midyear changes: Coverage generally effective the first of the month following a qualifying event

Midyear plan changes are allowed only when a qualifying event occurs, such as birth, marriage or loss of other group coverage. You must complete the appropriate form within 30 days of the event. Contact your benefit partner for more information.

ENROLLMENT

Benefit allowance

Your benefit allowance helps cover your costs

The state provides a benefit allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. Refer to the benefit allowances at the top of the plan rate charts at the beginning of this guide. **The amount of your allowance is determined based on the dependents you choose to include in health coverage.**

Online enrollment – Welcome to Workday@OK

Enroll online!

Online enrollment opens Oct. 1 and closes Oct. 31, 2023.

Refer to Contact Information at the end of this guide. Assistance is also available by contacting **servicedesk@omes.ok.gov.**

Log into Workday@OK, check your inbox and begin online enrollment to make your 2024 benefit elections. The average enrollment takes just a few minutes, and you can enroll anytime during Option Period.

Online enrollment allows you to:

- View/print your Benefits Statement to instantly see your elections.
- Change your elections and make corrections as many times as you like until the close of Option Period. **Your final election is the official enrollment.**
- Be sure to select Review and Sign. Review your elections, accept the electronic signature statement; select Submit, then View/Print your Benefits Statement to ensure

and verify your elections. **Verify that you have selected the correct tax withholding option, either before-tax or after-tax. All tax withholding elections must be consistent. Unless you are opting out of the Basic Plan, (health, dental, life insurance and disability), you must enroll in Basic 20,000 Life Insurance and Disability.**

Changes to benefit elections

Benefit elections made during Option Period are generally irrevocable. Changes can be made to Option Period elections only if the change is authorized and consistent with IRS regulations. If you experience an event that you believe qualifies you to change your benefit elections, log into Workday@OK, go to your Benefits app and select Benefits, then choose the appropriate midyear qualifying event from the Change Reason drop-down box. This event will then be sent to your benefits partner for approval. If you have any questions, contact your benefits partner.

Midyear changes

Life events that qualify you to change your benefit elections midyear include:

- Marriage.
- Birth.
- Adoption or placement of an adopted child.
- Loss of other coverage.
- Change in marital status.
- Change in the number of dependents.
- Change in employment status of employee, spouse or dependent that affects eligibility.
- Event causing employee's dependent to satisfy or cease to satisfy eligibility requirements.
- Change in place of residence of employee, spouse or dependent (HMO coverage).
- Commencement of or termination of adoption proceedings.
- Judgments, decrees or orders.
- Medicare or Medicaid (for dependents only).
- Significant cost increases (limited to DCA using unrelated care provider).
- Changes in coverage of spouse or dependent under other employer's plan (except HCA).
- Family and Medical Leave Act leave.
- Other events which may permit such modification of election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing IRS Code regulations promulgated under and in accordance with other applicable rules and regulations.

ELIGIBILITY

Members

- You must be a current state employee regularly scheduled to work at least 1,000 hours a year, and not classified as temporary or seasonal.
- Any current state employee regularly scheduled to work 30 hours per week shall be eligible for and offered insurance coverage under the provisions of the Patient Protection and Affordable Care Act.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to “Excluding dependents from coverage” in this section).
- Eligible dependents include:
  - Your legal spouse (including common-law).
  - Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
  - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval.
  - Other unmarried dependent children up to age 26, upon completion and approval of an Application for Coverage for Other Dependent Children. Guardianship papers or a tax return showing dependency can be provided in lieu of the application.
- If your spouse is enrolled separately in one of the plans offered through EGID, your dependents can be covered under either parent’s health, dental and/or vision plan, but not both. However, both parents can cover dependents under Dependent Life.
- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage or loss of other group coverage occurs. Dependent coverage can be dropped midyear with a qualifying event.
- Dependents can be enrolled only in the same types of coverage and in the same plans you elect for yourself.
- To enroll your newborn, the appropriate form must be provided to your benefits partner within 30 days of the birth. This coverage is effective the first of the birth month. If you do not enroll your newborn during this 30-day period, you cannot do so until the next annual Option Period. Direct notification to a plan will not enroll your newborn or any other dependents. The newborn’s Social Security number is not required at the time of initial enrollment but must be provided once it is received from the Social Security Administration. Insurance premiums for the month the child was born must be paid.
- Without newborn enrollment:
  - HealthChoice: A newborn has limited coverage without an additional premium only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Under the HealthChoice plans, a separate deductible and coinsurance apply.

- BCBSOK – BlueLincs, CommunityCare and GlobalHealth HMOs: A newborn is covered for 31 days without an additional premium.

- Newly hired employees and current employees with newly acquired dependents are required to provide documentation to verify dependent eligibility. Following is the acceptable documentation for dependent verification:

Spouse

Copy of your marriage certificate and one of the following:

- Copy of the front page of your filed 2022 federal tax return confirming this dependent is your spouse.
- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account.

Common-law spouse

Copy of a completed Affidavit of Common-Law Spouse and one of the following:

- Copy of the front page of your filed 2022 federal tax return confirming this dependent is your spouse.
- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account.

Children up to age 26 and disabled children

Birth certificate, hospital birth record or adoption certificate naming you or your spouse as the child's parent or a copy of the court order naming you or your spouse as the child's legal guardian.

- If you have any questions regarding verifying eligibility, please contact your benefits partner.

Opt-out details

With the approval of House Bill 1107 in May 2013 (which revised HB 2088), state employees and elected officials were given the right to opt out of state benefits. Specifically:

Any active employee eligible to participate or who is a participant may opt out of the state's basic plan as outlined in Sections 1370 and 1371 of this title, or may opt out of the health and dental basic plan options only and retain the life and disability plan benefits, provided that the participant is currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan at or before the beginning of the next plan year. Any active employee eligible to participate or who is a participant opting out of coverage pursuant to this section shall provide proof of their separate health insurance plan participation and sign an affidavit attesting that the participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting out of the state's basic plan or the health and dental basic plan options pursuant to this section shall receive $150 in lieu of the flexible benefit amount the employee would otherwise be eligible to receive.

Employees covered under Indian health, VA, Medicare, Medicaid or SoonerCare are not eligible to opt out. Dependents covered under SoonerCare are not eligible to opt out.

As the law states, you may opt out of the basic plan (health, dental, Basic Life and disability insurance), or you may opt out of health and dental benefits only if you are currently covered by a separate group health insurance plan or will be covered by Jan. 1, 2024. In addition, you must provide proof of that group health insurance plan participation and sign an affidavit before the opt-out will be approved.

State employees who have federal TRICARE insurance benefits and choose to enroll in the TRICARE Supplement Plan will opt out of health, dental, life, and disability. They can elect to participate in vision and flexible spending accounts.

The basic plan described in the law consists of the following: health, dental, Basic Life and disability insurance. If you opt out of the basic plan, you are no longer eligible for any of those coverages through the state. Because Basic Life insurance is a prerequisite for the optional Supplemental Life and Dependent Life, those are eliminated as well. However, if you opt out of health and dental only, you may retain both life and disability insurance. State employees who opt out can still take advantage of vision insurance offered by the state, as well as a flexible spending account. Employees must opt out each year because the election does not rollover.

If you are considering opting out of the basic plan, please understand you are forfeiting the normal benefit allowance provided by your agency. In lieu of that benefit allowance, you will get $150 per month from your agency, which can be used to pay for vision coverage, FSA contributions, added to your net pay as taxable income, or any combination thereof. If you are considering opting out of health and dental only, the $150 per month can be used to purchase additional life insurance or vision insurance, FSA contributions and/or added to your net pay as taxable income.

Note: You must renew your opt-out each year – it will not rollover.

Excluding dependents from coverage

- You can exclude your spouse from health, dental and/or vision coverage while covering other dependents on these benefits. Your spouse must sign the Spouse Exclusion Certification section of your enrollment or change form. Check with your benefits partner for more information.
- You can exclude dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage or are eligible for Indian or military health benefits.

Transfer employee

You can keep your coverage continuous when you move from one participating employer to another as long as there is no break in coverage that lasts longer than 30 days. Premiums must be paid upon reporting to work.

Retiring and changing plans

If you are retiring on or before Jan. 1, 2024, go to **oklahoma.gov/omes/services/employees-group-insurance-division** for the appropriate Option Period materials. Select the Option Period banner, then select (according to your status as of Jan. 1) Pre-Medicare or Medicare. Your benefits partner can assist you and must also provide you the required Application for Retiree/Vested/Non-Vested/Defer Insurance. If you or your dependents will be Medicare eligible by Jan. 1, an additional form will be required to enroll in one of the Medicare

Supplement plans or Medicare Advantage prescription drug plans. You can also call EGID for assistance. Refer to Contact Information at the back of this guide.

Termination of coverage

- Coverage will end the last day of the month in which a termination event occurs, such as:
  - Loss of employment.
  - Reduction in hours.
  - Loss of dependent eligibility.
  - Non-payment of premiums.
  - Death.

COBRA: Temporary continuation of coverage

The Consolidated Omnibus Budget Reconciliation Act allows you and/or your covered dependents to continue health, dental and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. Contact your benefits partner immediately upon termination of your employment, or when changes to your family status occur, to find out more about your COBRA rights. **Be aware, dropping dependent coverage during Option Period is not a COBRA qualifying event.**

STATE SHARED LEAVE PROGRAM

The state leave sharing program permits state employees to donate annual or sick leave to fellow state employees who have exhausted or will exhaust all types of leave. The Leave of Last Resort Bank was created for qualifying employees who are unable to obtain the necessary number of donated leave hours from his or her agency. The Leave of Last Resort Bank is administered by OMES and funded by voluntary donations of annual and sick leave from employees retiring or leaving state service (donor). The donor may donate any of their excess leave to the Leave of Last Resort Bank. Employees retiring or leaving state service may submit the **Separation from State Service Donation to Leave Bank Form (HCM-33C)** to their agency HR for further submission to the state shared leave liaison.

Current state employees also may donate leave to a co-worker in need of shared leave by submitting the **Request to Donate Shared Leave Form (HCM-33B)** to their Agency HR for verification and approval.

If an employee is in need of shared leaved, they may submit the **Request to Receive Shared Leave/Bank Leave Form (HCM-33A)** to their agency HR for verification and approval. The agency seeks to secure leave from within. If none is found, the request moves to the state shared leave liaison who will seek to secure leave from the employing agency, other state agencies and the Leave of Last Resort Bank. The requesting employee and the employing agency must also continue to advocate for leave for the requesting employee.

For any questions regarding the state leave sharing program, email **HCMClassComp@omes.ok.gov.**

Thrive: Oklahoma Employee WELLNESS

Thrive is the state employee wellness program that has been in existence since 2005. Our mission is to empower State of Oklahoma employees to improve and enhance their overall well-being. Our program revolves around eight components of wellness—physical, emotional, environmental, financial, intellectual, occupational, social and spiritual—by providing programs that include a variety of education, activities and challenges for state employees and their families. It's our journey and our promise to help the State of Oklahoma workforce cultivate excellence and in short, Thrive.

Our approach is to provide programs that motivate and challenge employees to desire to live happy and fulfilled lives by achieving total well-being.

Thrive's website and social media house all this information. We invite employees and their families to visit our website at **oklahoma.gov/thrive** where you can link to our social media accounts and sign up for our monthly newsletter and program updates.

HMO ZIP CODE LISTS

BCBSOK – BlueLincs ZIP code list

73001	73002	73003	73004	73005	73006	73007	73008	73009
73010	73011	73012	73013	73014	73015	73016	73017	73018
73019	73020	73021	73022	73023	73024	73025	73026	73027
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CommunityCare ZIP code list

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GlobalHealth ZIP code list

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74875	74878	74880	74881	74883	74884			

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	$4,000 individual $12,000 family Includes medical and pharmacy	$4,000 individual $8,000 family Includes medical and pharmacy	$4,000 individual $12,000 family Includes medical and pharmacy
Office Visit	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist (PCP referral is not required to see most specialists)	$0 copay/PCP $50 copay/specialist

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Calendar Year Deductible (for pharmacy deductible, refer to Page 31)	High plan $750 individual $2,000 family High Alternative plan $1,000 individual $2,750 family Copays do not apply to deductible Separate pharmacy deductible A family is three or more covered individuals	$1,750 individual $3,500 family One member may be responsible for up to the full family deductible The combined medical and pharmacy deductible must be met before benefits are paid A family is two or more covered individuals	Medical First-Dollar Coverage Plan pays first $500 (Basic) or $250 (Basic Alternative) per covered family member for covered expenses Medical Deductible After first-dollar coverage, you pay the deductible for covered expenses Basic: $1,000 individual or $1,500 family Basic Alternative: $1,250 individual or $1,750 family A family is two or more covered individuals Medical Coinsurance (Basic and Basic Alternative) After medical deductible, you pay 50% and plan pays 50% for covered expenses until your out-of-pocket maximum is reached Medical Calendar Year Out-of-Pocket Maximum (Basic and Basic Alternative) $4,000 maximum per member, no more than $9,000 per family Deductible and coinsurance apply to maximums. Once your maximum limit is met, the plan pays 100% of allowable amounts for covered services For pharmacy deductible, refer to Page 31
Calendar Year Out-of-Pocket Maximum	High plan $3,300 individual $8,400 family High Alternative plan $3,550 individual $8,400 family For both plans: Deductible, coinsurance and copays apply; excludes pharmacy expenses	$6,000 individual $12,000 family Deductible, coinsurance and copays apply; includes pharmacy expenses	
Office Visit	$30 copay/general physician $50 copay/specialist	You pay 100% of allowable amounts until deductible is met $30 copay/general physician $50 copay/specialist	First-dollar coverage, then 50% of allowable amounts after deductible

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
X-Ray and Lab	$25 copay for X-ray and lab $250 copay per scan or procedure for FOCUS Procedures (MRI, CT, PET, EEG, ECG, MPS and similar); and pathology and lab under CPT codes of cytogenetic studies, surgical pathology or transcutaneous procedures	$0 copay for routine X-ray and lab $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	$10 copay for X-ray and lab For MRI, MRA, PET, CAT and nuclear scans: $250 copay per scan in a preferred facility $750 copay per scan in a non-preferred facility
Allergy Testing and Treatment	$25 copay/PCP $50 copay/specialist Serum and shots including a 6-week supply of antigen	$35 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen	$0 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen and administration
Preventive Services	$0 copay (PCP or specialist) $0 copay per OB/GYN visit, no referral required for annual routine services	$0 copay (PCP or specialist) $0 copay for well-woman visit, no PCP referral required	$0 copay PCP/routine physical exam $0 copay well-woman exam and preventive services
Well-Child Care	$0 copay	$0 copay	$0 copay per well-child visit
Immunizations	$0 copay	$0 copay birth through age 20 years $0 copay ages 21 and older when following the recommendation of ACIP	$0 copay when following the recommendation of ACIP

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Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
X-Ray and Lab	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Allergy Testing and Treatment	20% of allowable amounts after deductible Limit of 60 tests every 24 months	20% of allowable amounts after deductible Limit of 60 tests every 24 months	First-dollar coverage, then 50% of allowable amounts after deductible Limit of 60 tests every 24 months
Preventive Services (for full list, refer to HealthChoiceOK.com)	$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older	$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older	$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older
Well-Child Care	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance
Immunizations	No charge for well-child and adult immunizations and administration $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration Office visit: First-dollar coverage, then 50% of allowable amounts after deductible

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Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Hearing Screening and Hearing Aid	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance
Hospital Inpatient	$1,000 copay per day $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$300 copay per day $900 maximum per admission
Hospital Outpatient	$750 copay per day	$300 copay per visit	$300 copay in a preferred facility $800 copay in a non-preferred facility
Emergency Room	$300 copay; waived if admitted	$200 copay; waived if admitted	$400 copay for facility charge; waived if admitted
Urgent Care	$50 copay for outpatient or professional urgent care facility per visit	$50 copay per visit	$25 copay per visit
Maternity Prenatal and Postnatal Care	$0 copay for prenatal and postnatal care $2,000 copay per admission	$0 copay for preventive prenatal and postnatal care $35 copay/PCP $50 copay/ specialist for confirmation visit $350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$0 copay for prenatal and postnatal care $500 per hospital admission

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Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Hearing Screening and Hearing Aid	Hearing screening $30/$50 copay unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening $30/$50 copay after deductible unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required First-dollar coverage, then 50% of allowable amounts after deductible
Hospital Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Hospital Outpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible.	First-dollar coverage, then 50% of allowable amounts after deductible
Emergency Room	$200 copay – waived if admitted 20% of allowable amounts after deductible	$200 copay – waived if admitted 20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Urgent Care	$30 office visit copay 20% of allowable amounts after deductible	$30 office visit copay after deductible 20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Maternity Prenatal and Postnatal Care	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: First-dollar coverage, then 50% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)

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Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health or Substance Use Disorder Inpatient	$1,000 copay per day $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	Residential treatment center or medical detox $300 copay per day $900 maximum per admission
Mental Health or Substance Use Disorder Outpatient	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $0 copay/facility $0 copay/Applied Behavioral Analysis	$0 copay per visit
Occupational or Speech Therapy Visit	$0 copay inpatient $50 copay per outpatient therapy Limit of 60 visits combined for all therapies per year	Inpatient $350 copay per day $1,750 maximum per admission (May be subject to prior authorization) $50 copay per outpatient therapy visit Up to 60 days treatment per disability	$0 copay inpatient $35 copay per outpatient visit Limit of 60 treatment days per course of therapy
Physical Therapy or Physical Medicine Visit			

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Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Durable Medical Equipment	20% of allowable amounts after deductible for purchase, rental, repair or replacement	20% of allowable amounts after deductible for purchase, rental, repair or replacement	First-dollar coverage, then 50% of allowable amounts after deductible
Mental Health or Substance Use Disorder Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, then 50% of allowable amounts after deductible
Mental Health or Substance Use Disorder Outpatient	20% of allowable amounts after deductible Limit: 20 services/year without certification	20% of allowable amounts after deductible Limit: 20 services/year without certification	First-dollar coverage, then 50% of allowable amounts after deductible Limit: 20 services/year without certification
Occupational or Speech Therapy Visit	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	First-dollar coverage, then 50% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required
Physical Therapy or Physical Medicine Visit	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	First-dollar coverage, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum

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Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Chiropractic and Manipulative Therapy Visit	$50 copay Included under physical and occupational therapy, no separate visit limit per year	$50 copay No visit limits	$25 copay Limit 15 visits per year
Bariatric Surgery	$1,000 copay per day $3,000 maximum per admission	$350 copay per day $1,750 maximum per admission (May be subject to prior authorization)	$300 per day $900 maximum per admission
National Diabetes Prevention Program	Covered at 100%	Covered at 100%	Covered at 100%
Telehealth/ Telemedicine	Covered services are covered at regular plan provisions MDLIVE covered at 100%	$35 copay/PCP $50 copay/Specialist $0 copay/Preventive	Covered same as office visit if provider offers telehealth/telemedicine services

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for NetworkServices	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Chiropractic and Manipulative Therapy Visit	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy First-dollar coverage, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits
Bariatric Surgery	20% of allowable amounts after deductible; some limitations and exclusions apply	20% of allowable amounts after deductible; some limitations and exclusions apply	First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply
National Diabetes Prevention Program	$0 copay for preventive service	$0 copay for preventive service	$0 copay for preventive service
Telehealth/ Telemedicine	20% of allowable amounts after deductible; some limitations and exclusions apply $30/$50 office visit copay may apply SwiftMD: $0 fee and no coinsurance	20% of allowable amounts after deductible; some limitations and exclusions apply. $30/$50 office visit copay may apply SwiftMD: $45 fee until deductible is met. $0 fee and no coinsurance after meeting deductible	First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply SwiftMD: $0 fee and no coinsurance

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Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	Retail or Mail Order (30-day supply) Preferred generic: $5 Non-preferred generic: $15 Preferred brand: $40 Non-preferred brand: $80 Insulin*: No more than $30 (90-day supply) Preferred generic: $10 Non-preferred generic: $30 Preferred brand: $80 Non-preferred brand: $160 Insulin*: No more than $90 Specialty Preferred: $100 Non-preferred: $200 **Drug formulary has changed to the BCBSOK Performance Drug List.** *Only insulin included on current drug list.	Retail (30-day supply) Select generic: $0 Preferred generic/Tier 1: $15 Preferred brand/Tier 2: $40* Non-preferred brand or generic/Tier 3: $70* Specialty/Tier 4: $160* Member cost share will not exceed $30 for a 30-day supply of insulin. Mail Order (90-day supply) Select generic: $0 Preferred generic/Tier 1: $45 Preferred brand/Tier 2: $120* Non-preferred brand or generic/Tier 3: $210* Mail Order (30-day supply) Specialty/Tier 4: $160* *If you choose to obtain a brand-name drug when a generic is available, you pay the applicable copay or coinsurance for the brand-name drug, plus the difference in cost between the brand-name drug and its generic equivalent. The difference in cost between the brand-name drug and its generic equivalent will not count toward your annual out-of-pocket maximum.	Retail or Mail Order (30-day supply) Tier 1 generic: $20 Preferred brand: $65 Non-preferred drugs: $90 Insulin: No more than $30 (90-day supply) Tier 1 generic: $40 Preferred brand: $130 Non-preferred drugs: $180 Insulin: No more than $90 Specialty (30-day supply) Preferred: $200 Non-preferred: $400

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Your Costs for Network Services	HealthChoice High, High Alternative, Basic, Basic Alternative and HDHP Plans The applicable pharmacy or, for HDHP, combined deductible must be met before pharmacy copays apply.	
Pharmacy Deductible	HealthChoice High, High Alternative, Basic and Basic Alternative $100 for individual $300 for family	HealthChoice HDHP Medical and pharmacy combined $1,750 for individual $3,500 for family
Prescription Medications	**30-Day Supply**	**90-Day Supply**
Generic Drugs	Up to $10	Up to $25
Preferred Drugs	Up to $45	Up to $90
Non-Preferred Drugs	Up to $75	Up to $150
Specialty Drugs	Generic – $10 copay Preferred drugs – $100 copay Non-preferred drugs – $200 copay	30-day copays apply to each additional 30-day supply
Insulin	No more than $30	No more than $90

Note: Only FDA approved drugs and drugs with FDA Emergency Use Authorizations are covered. Experimental treatments and unapproved drugs and drugs not approved or not authorized for emergency use by the FDA are not covered under this plan.

HealthChoice Preventive Medication List – These medications are not subject to pharmacy deductible on the High, High Alternative, Basic or Basic Alternative plans, or the combined medical/pharmacy deductible on the HDHP.

All plan provisions apply. Some medications are subject to prior authorization and/or quantity limits. If you choose a brand-name medication when a generic is available, you are responsible for the difference in the cost in addition to the copay.

HealthChoice covers **up to a 168-day supply** of tobacco cessation medications at 100% when filled at a network pharmacy. Visit the **HealthChoice Be Tobacco Free page** for details.

CDC-recommended vaccinations, such as for shingles, are covered at 100% when using a network pharmacy. **NOTE:** These can also be covered under the health benefit if provided by a recognized network health provider, such as a physician or health department.

Amounts paid by copay assistance programs, manufacturer copay cards or other third parties do not apply toward deductibles or out-of-pocket maximums.

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Annual Deductible	Network: $25 individual/$75 family Basic and Major services combined Non-network: $25 individual/$75 family Preventive, basic and major services combined plus amounts above allowable fees	Network: $50 individual/$150 family Basic and Major services combined Non-network: $50 individual/$150 family Preventive, basic and major services combined plus amounts above allowable fees
Diagnostic and Preventive Care (cleanings, routine oral exams)	Network: 0% Non-network 0% after charges above the allowable amounts	Network: 0% Non-network 0% after maximum allowed charge
Basic Care (extractions, oral surgery)	Network: 15% in-network after deductible Non-network: 30% after deductible and charges above the allowable amounts	Network: 15% in-network after deductible Non-network: 30% after deductible and maximum allowed charge

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Annual Deductible	No deductible $0 office copay	No deductible $5 office copay
Diagnostic and Preventive Care (cleanings, routine oral exams)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example services/copays: Sealant per tooth: $12 copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example services/copays: Sealant per tooth: $17 copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
Basic Care (extractions, oral surgery)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example service/copay: Amalgam – one surface, permanent teeth: $0 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example service/copay: Amalgam – one surface, permanent teeth: $23 copay

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Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Annual Deductible	Network and non-network: $25 per person, per year. Applies to Basic and Major services only.	Network and non-network: $100 per person per year. Applies to only Major Restorative (Level 4) services.	Network: $25 individual $75 family Basic and major services combined Non-network: $25 individual $75 family Preventive, basic and major services combined Separate network and non-network deductibles A family is 3 or more covered individuals.
Diagnostic and Preventive Care (cleanings, routine oral exams)	Network and non-network: Member pays 0% of allowable amounts. No deductible or copayments. Routine Cleanings, Oral Evaluations and X-rays are considered Diagnostic and Preventive (Level 1) services. No waiting periods.	Network and non-network: Member pays copayments for all tiers of service (Levels 1-5) based on a fee table. No deductible. Routine Cleanings, Oral Evaluations and X-rays are considered Diagnostic and Preventive (Level 1) services. No waiting periods.	Network: You pay $0 Non-network: You pay $0 after deductible plus charges above the allowable amounts
Basic Care (extractions, oral surgery)	Network and non-network: Member pays 15% of allowable amounts. Deductible applies. Endodontics, Periodontics and Oral Surgery are considered Basic services. No waiting periods.	Network and non-network: Member pays copayments for Basic (Levels 2 and 3) services as outlined in the fee table. No deductible. Endodontics, Periodontics and Oral Surgery are considered Basic services. No waiting periods.	Network: You pay 15% after deductible Non-network: You pay 30% after deductible plus charges above the allowable amounts

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Annual Deductible	Member pays Network and non-network: $25 individual/$75 family Basic and Major Care combined	Member pays Network and non-network: $50 individual/$150 family Basic and Major Care combined	$30 per person, waived for network preventive services
Diagnostic and Preventive Care (cleanings, routine oral exams)	Member pays Network: $0 Non-network: Amounts above maximum allowed charge	Member pays Network: $0 Non-network: Amounts above maximum allowed charge	Network: Plan pays 100% of allowable amounts. No deductible. Non-network: Plan pays 100% of usual and customary after deductible
Basic Care (extractions, oral surgery)	Member pays Network: 15% Non-network: 15% plus amounts above maximum allowed charge Deductible applies	Member pays Network: 30% Non-network: 30% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 85% of allowable amounts after deductible Non-network: Plan pays 70% of usual and customary after deductible

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Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Major Care (dentures, bridge work)	Network: 40% after deductible Non-network: 50% after deductible and charges above the allowable amounts	Network: 50% after deductible Non-network: 50% after deductible and maximum allowed charge
Orthodontic Care	Network: 50%. Deductible waived Non-network: 50% after charges above the allowable amounts $5,000 Lifetime maximum Dependents covered up to age 19 No waiting period for orthodontic benefits	Network: 50%. Deductible waived Non-network: 50% after maximum allowed charge $1,500 Lifetime maximum Dependents covered up to age 19 No waiting period for orthodontic benefits
Plan Year Maximum	$2,500	$1,500
Filing Claims	Network: No claims to file Non-network: You may file claims; provider may file claims.	Network: No claims to file Non-network: You may file claims; provider may file claims.

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Major Care (dentures, bridge work)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays: Root Canal, Anterior: $210 copay Periodontal Scaling/Root planning 1-3 teeth (per quadrant): $42 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays: Root Canal, Anterior: $375 copay Periodontal Scaling/Root planning 1-3 teeth (per quadrant): $75 copay
Orthodontic Care	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) $2,040 out-of-pocket child $2,376 out-of-pocket adult (24-month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) $2,472 out-of-pocket child $3,384 out-of-pocket adult (24-month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits
Plan Year Maximum	Plan year maximum is unlimited No plan year dollar maximum	Plan year maximum is unlimited No plan year dollar maximum
Filing Claims	There is no applicable copayment schedule for the Cigna Dental Prepaid K1I09 plan. The plan is based on a fee schedule. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. No claim filing is necessary, the network provider will bill you based on the agreed upon fee schedule.	There is no applicable copayment schedule for the Cigna Dental Prepaid OKIV9 plan. The plan is based on a fee schedule. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. No claim filing is necessary, the network provider will bill you based on the agreed upon fee schedule.

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Major Care (dentures, bridge work)	Network and non-network: Member pays 40% of allowable amounts. Deductible applies. Restorations, Prosthodontics, and Implants are considered Major services. No waiting periods.	Network and non-network: Member pays on a service-by-service basis with copayments for all tiers of service (Levels 1-5) as outlined in the fee table. Deductible applies. Restorations, Prosthodontics, and Implants are considered Major services. No waiting periods.	Network: You pay 40% after deductible Non-network: You pay 50% after deductible plus charges above the allowable amounts.
Orthodontic Care	Network and non-network: Plan pays 60% of allowable amounts up to $2,000 lifetime maximum per person. Orthodontic benefits are available to eligible employees, spouses and dependent children and are paid in periodic or monthly intervals. No deductible. No waiting periods.	Network and non-network: Plan pays up to the $1,800 lifetime maximum per person. Orthodontic (Level 5) services are paid in periodic or monthly intervals and copayments are based on a fee table. Orthodontic benefits are available to eligible employees, spouses and dependent children. No deductible. No waiting periods.	Network: You pay 50% of allowable amounts; no deductible applies Non-network: You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies Covered for members under age 19 Covered for treatment of TMD at any age No lifetime maximum 12-month waiting period for orthodontic benefits (some exceptions apply)
Plan Year Maximum	Network and non-network: $2,500 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.	Network and non-network: $2,000 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.	Network and non-network: $2,500 per person You are responsible for all charges billed by provider after plan year maximum is met.
Filing Claims	Network dentists are required to submit claims on behalf of the member. Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.	Network dentists are required to submit claims on behalf of the member. Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.	Network: No claims to file. Non-network: You file claims.

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Major Care (dentures, bridge work)	Member pays Network: 40% Non-network: 40% plus amounts above maximum allowed charge Deductible applies	Member pays Network: 50% Non-network: 50% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 60% of allowable amounts after deductible Non-network: Plan pays 50% of usual and customary after deductible
Orthodontic Care	Member pays Network: 40% Non-network: 40% plus amounts above maximum allowed charge $5,000 lifetime maximum per person	Member pays Network: 50% Non-network: 50% plus amounts above maximum allowed charge $2,000 lifetime maximum per person	Network: Plan pays 60% Non-network: Plan pays 50% up to lifetime maximum of **$1,500** for dependents under age 19 12-month waiting period applies
Plan Year Maximum	Network and non-network: $5,000 per person, per year	Network and non-network: $1,500 per person, per year	**$1,750** per person, per policy year
Filing Claims	Network and non-network: Claims are filed for all services performed. Most claims are submitted by dentists on behalf of the member.	Network and non-network: Claims are filed for all services performed. Most claims are submitted by dentists on behalf of the member.	Network and non-network: Member or provider must file claims, depending on the provider.

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

COMPARISON OF BENEFITS FOR VISION PLANS

	Primary Vision Care Services		Superior Vision	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	$0 copay No limit to frequency	Plan reimburses up to $40 Limit one exam	Covered in full after $10 copay 1 per Calendar Year	$10 copay Up to $34 (MD) Up to $26 (OD) 1 per Calendar Year
Lenses Per Pair	You pay wholesale cost No limit to number of pairs	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay 1 pair per Calendar Year Standard Lenses: Single-covered in full Bifocal-covered in full Trifocal-covered in full Standard Progressives-Covered in full	$25 copay 1 pair per Calendar Year Standard lenses: Single-up to $26 Bifocal-up to $39 Trifocal-up to $49 Standard Progressives-up to $39

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

	Vision Care Direct		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	$15 copay for full comprehensive exam including dilation Retinal Fundus Image, no more than a $39 fee	Reimbursed up to $50	Covered in full after $10 copay Limit one exam per calendar year	Reimbursed up to $45 after $10 copay Limit one exam per calendar year
Lenses Per Pair	$15 copay Single vision, bifocal, trifocal, lenticular lenses At a PLUS PLAN Provider, you receive free upgrades for no-line progressive lenses with high quality antireflection, scratch and UV coatings (refer to Vision Notes for details)	Reimbursed up to: $50 single $75 bifocal $100 trifocal $100 progressive	Standard lenses covered in full after $25 material copay Polycarbonate lenses covered in full for dependent children Standard Progressives and UV protection covered in full Up to 30% savings on popular lens options	Reimbursed up to: $30 Single $50 Bifocal $65 Trifocal $100 Lenticular $50 Progressive $25 materials copay applies

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

	Primary Vision Care Services		Superior Vision	
Covered Services	Network	Non-Network	Network	Non-Network
Frames	You pay wholesale cost No limit to number of frames	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay $150 retail allowance 1 per Calendar Year	$25 copay Up to $81 1 per Calendar Year
Contact Lenses	You pay wholesale cost for annual supply of contacts Members are eligible for prescription glasses and contact lenses in the same year	Limit of one set annually in lieu of eyeglasses You pay normal doctor's fees reimbursed up to $60	$25 CL Fit copay 1 Allowance per Calendar Year $150 Retail Allowance (Contact lenses are in lieu of eyeglass lenses and frames.)	CL Fit Not Covered Up to $100 1 Allowance per Calendar Year (Contact lenses are in lieu of eyeglass lenses and frames.)
Laser Vision Correction	Through nJoy Vision in Oklahoma City and OMEG in Tulsa Discount up to $1,000 off Lasik	No benefit	Discount available	N/A

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

	Vision Care Direct		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Frames	Covered in full up to $150	Reimbursed up to $80	Covered in full up to $170 or $220 for featured frame brands and 20% discount on any overage. $95 frame allowance at Walmart/Sam's Club and Costco	Reimbursed up to $70 $25 materials copay applies
Contact Lenses	$150 allowance, in lieu of glasses. Contact Fitting Fees: Standard: $65 Max Specialty: $200 Max $750 allowance for Medically Necessary Contacts	$80 allowance, in lieu of glasses	$120 allowance, in lieu of glasses Up to $60 copay for contact lens exam (fitting and evaluation) Medically necessary contacts are covered in full after the $25 material copay	Reimbursed up to $105, in lieu of glasses Medically necessary contacts are covered up to $210 after the $25 copay
Laser Vision Correction	Up to $1,000 discount at any of our Lasik providers. In addition to the discount, $200 LASIK Reimbursement in lieu of glasses or contacts. Go to: **ok.vision/lasik-discount-network**	No benefit	Average discount of 15% off regular price or 5% off promotional price	No benefit

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the back of this guide.

VISION PLAN NOTES

PVCS: The only Oklahoma owned and operated vision care plan with unlimited network services. Member must select either network or non-network for entire year. Network services are unlimited. Non-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50 copay applies to soft contact lens fittings; a $75 copay applies to rigid or gas permeable contact lens fittings or refittings; and a $150 copay applies to hybrid contact lens fittings or refittings. Simple replacements are not assessed with these fees. Limitations/exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non-routine vision services and tests, 4) Luxury frames, 5) Premium prescription lenses, and 6) Nonprescription eyewear. For more information and details, call 888-357-6912 or visit our website at **pvcs-usa.com/okstate**.

Superior: Vision Plan information/detail is available at **https://microsite.versanthealth.com/stateofoklahoma/**. Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with DP in their listing. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount with provider offices that accept our discount plans. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct of Oklahoma: Oklahoma Owned and Operated by Optometrists. With VCD of OK, you get your exam, frames, and lenses with free enhancements (progressive lenses with premium anti-reflective and UV coatings) for $30. Our Frame/Contact Lens Allowance to $150 and we raised our Medically Necessary Contact Allowance to $750. We created limits on what you pay for Contact Fitting Fees. For Standard Contact Fitting pay no more than $65 and Specialty Fittings no more than $200. With our plan we allow you to use your Contact Lenses Allowance to pay for your Fitting Fee and/or to purchase contacts. This allows you to use your allowance to pay for your fitting and potentially a portion of your contacts, whichever makes the best financial sense for you. Other plans offer discounts for materials such as UV, Scratch, UV Coatings, and Progressive lenses but VCD of OK takes a different approach and includes these extras at NO ADDITIONAL COST! When you compare the total cost of your premiums and what you spend in the doctor's office, in most cases, we offer a plan that will save you money. Choosing an OK company means your customer service is in state to help you. It also means that you support your local community and schools when you buy a plan based in Oklahoma! VCD of OK is not an insurance company so our focus is on delivering the very best patient care with quality materials at a very affordable price because we want you to SEE THE DIFFERENCE. Visit **okstate.vision** for more information and to search for providers in your area. (To get the free upgrades mentioned above simply look for the "VCD Plus" logo when searching for a provider.)

VSP: Exam, lenses and frame benefit provided annually. The $25 materials copay applies to lenses or frames, but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If choosing a frame valued at more than the allowance, member saves 20% on out-of-pocket costs when using a VSP doctor. Member receives an extra $50 toward frame allowance when selecting a Marchon or Altair frame brand. Contact lenses are in lieu of spectacle lenses and frame. The $120 network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to $60. The $105 non-network allowance applies to the contacts and contact lens exam. Contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses – member receives an extra 20% off additional complete pairs of glasses, sunglasses or lens options at any VSP provider within last 12 months from exam. Contact VSP or visit **vsp.com** to learn more. VSP members can now use and integrate their benefits online, via **eyeconic.com**. Oklahoma enrollees can virtually try on each pair in the extensive catalog of glasses and sunglasses. Members can order glasses and contacts while using their VSP benefit. In addition to your VSP vision insurance, any additional savings will automatically be applied at the time of purchase. Frames can be sent directly to your door, or your provider's office for a final fitting, adjustment, and confirmation that you are completely satisfied.

FLEXIBLE SPENDING ACCOUNTS

The health care account and dependent care account allow you to set aside money from your paycheck, pretax, to pay for after-insurance, qualified medical expenses, deductibles, copays, qualified over-the-counter items (check your pharmacy's website for qualified over-the-counter items and planned dependent care charges.

Important Notes on FSA Accounts for Plan Year 2024

- You must enroll every year.
- Indicate your per-pay-period contribution when you enroll.
- FSA grace period is two and a half months. Any participant can receive reimbursement for qualified expenses incurred during Plan Year 2024 and also during the grace period (Jan. 1, 2025-March 15, 2025).
- FSAs use-it-or-lose-it rule is in effect for Plan Year 2024. You must incur services no later than March 15, 2025. Any money remaining will be forfeited, unless claimed with a manual form no later than March 31, 2025. It is important to forecast your expected expenses when enrolling in an FSA.
- You cannot enroll in an FSA if you enroll in the HealthChoice HDHP.
- You may be restricted from contributing to the health savings account if you have funds remaining in your FSA on Jan. 1, 2024.
- You can continue to participate in the DCA if you elect the HealthChoice HDHP.
- Distributions from a health FSA must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage.

When calculating your FSA contribution for the upcoming plan year, it is important to plan conservatively. Calculate based on your plan year estimated expenses, such as prescription costs, copays, dependent care costs and other qualifying expenses. The grace period may help reduce your risk of losing unused funds in your FSA account.

If you terminate employment with the state, any day care or medical services must be incurred prior to the last day of your termination month. Manual claims can be filed for such expenses incurred through March 31, 2025. If you are not on active payroll (some type of leave), it is your responsibility to mail in your pledged contribution.

Health Care Account/Flexible Spending Account

The Plan Year 2024 HCA limit, set by the IRS, increased to $3,200. Employees may elect up to the maximum limit for 2024. Employees may raise their withholdings by contacting their benefits partner by Dec. 15, 2023. You can realize significant tax savings on qualified, unreimbursed expenses by paying for the services and items pretax. Some qualifying expenses include:

- Doctor visits, deductibles and copays.
- Dental care, including orthodontic expenses.

- Prescription drugs.
- Physical therapy.
- Vision care, laser eye surgery, eyeglasses and lenses.

HCA Pretax Withdrawal Limits

- HCA monthly minimum: $10.
- HCA biweekly minimum: $5.
- HCA monthly maximum: $266.66 (subject to change depending on IRS limit).
- HCA biweekly maximum: $133.33 (subject to change depending on IRS limit).

Dependent Care Account

By enrolling in the DCA, you can set aside up to $5,000 (combined total per household) for your qualified day care-related expenses. By contributing to the DCA, you can use pretax dollars to pay for day care for:

- Your qualifying child who is your dependent and who was under age 13 when the care was provided.
- Your spouse who wasn't physically or mentally able to care for themselves and lived with you for more than half the year.
- A person who wasn't physically or mentally able to care for themselves, lived with you for more than half the year, and either:
  - Was your dependent.
  - Would have been your dependent, except that:

    They received gross income of $4,050 or more.

    They filed a joint tax return.

    You, or your spouse if filing jointly, could be claimed as a dependent on someone else's previous year's tax return.

DCA Pretax Withdrawal Limits

- DCA monthly minimum: $50.
- DCA biweekly minimum: $25.
- DCA monthly maximum: $416.66.
- DCA biweekly maximum: $208.33.
- Below is an example of how an average person, contributing just $100 per month, can increase their take-home pay by using an FSA:

	Without FSA	With FSA
Annual Salary	$35,000	$35,000
Flexible Spending Account Deposit (annual)	$0	$1,200
Taxable Income	$35,000	$33,800
Estimated Taxes (30%)	-$10,500	-$10,140
Health Care Expenses	-$1,200	$0
Take-home Pay	$23,300	$23,660
Annual Increase in Take-home Pay		$ 360

Run-Out Period

The run-out period means the 90-day period following a plan year in which claims can be made for reimbursable expenses incurred during the plan year. You cannot pay for prior year expenses from current year account funds. All expenses use the date of service, not the date they are paid, for eligibility purposes.

Grace Period

The IRS allows a grace period extension for incurring approved expenses that are reimbursable from your FSA. You have until March 15 of the following year to use funds from your current year's account.

For individual account information contact:

P&A Group

P&A Group will handle all claims for flexible spending accounts. This includes both health care accounts and dependent care accounts.

Customer Service hours: Monday-Friday, 7:30 a.m.-9 p.m. CST

Visit **padmin.com** or call 716-852-2611 or 800-688-2611.

Save on Your Taxes

IRS-approved election allows you to save money by not paying taxes on your eligible insurance premiums and FSA contributions. By paying eligible insurance premiums and contributions to FSAs with pretax dollars, you have more take-home pay than if you paid the same premiums with after-tax dollars. Be sure to choose the **plan name - Before tax** for these tax savings. Choose the **plan name - Post tax** if you want your out-of-pocket expense to be deducted post tax.

If you have questions, be sure to ask your benefits partner.

ADDITIONAL BENEFITS

Voluntary Payroll Deduction

The Voluntary Payroll Deduction program is a benefit offered to state and some educational employees so they may request payroll deductions from their paychecks to automatically be paid.

Deductions include but are not limited to employee association dues, educational employee organizations, employee association foundation contributions, payments to credit unions, banks or savings associations, payments to supplemental insurance and retirement plans, payments to a college savings account, and subscriptions to Oklahoma Today magazine.

To learn more about voluntary payroll deduction and the participating vendors, go to **oklahoma.gov/omes/services/employee-benefits/voluntary-payroll-deduction**.

988 Mental Health LifeLine

988 is a direct, three-digit lifeline that connects you with trained behavioral health professionals that can get all Oklahomans the help they need.

It all starts when you call 988. You'll be connected to a mental health professional to talk you through what's going on and get the resources you need for either yourself or your loved one. About 90% of the time, things can get sorted out with just a phone call. But if you need more help, we got you. For further information please go to 988 Mental Health LifeLine website at **988oklahoma.com**.

Other benefits employees may be eligible to receive, include:

- Retirement plans.
- Leave benefits.
- Longevity.
- Paid holidays.
- Unemployment and workers' compensation.
- Employee Assistance Program.

CONSUMER INFORMATION AND ANNUAL NOTICES

OMES Human Capital Management and OMES EGID comply with the Health Insurance Portability and Accountability Act of 1996 known as HIPAA. OMES HCM and EGID and each HMO, dental and vision plan offered to state employees have a privacy notice that describes the organization's protections and acceptable uses of information.

To obtain a privacy notice from a particular plan, contact the plan directly or contact OMES HCM. HIPAA also provides you and your dependents certain rights to enroll if you lose your group health plan coverage. HIPAA also prohibits a group health plan from keeping you (or your dependents) out of the plan based on anything related to your health. Finally, HIPAA gives you the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without preexisting condition exclusions.

The HealthChoice medical products offered by EGID are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on preexisting conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity and reconstructive mastectomies. Refer to General Eligibility Information for more details.

The Mental Health Parity and Addiction Equity Act, a federal law, requires health insurance providers to include mental health and substance use disorder coverage equal to physical health coverage in terms of the financial and treatment requirements. The law removed differences in copays and removed limits on visits and treatment days. Provisions of the law went into effect in all of the state's available health plans in 2019.

The Women's Health and Cancer Rights Act of 1998, a federal law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 866-444-3272.

The Breast Cancer Patient Protection Act, an Oklahoma state law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection.

The Newborns and Mothers Act of 1996, a federal law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery.

The Mandated Benefit for OB/GYN Coverage Law requires any health benefit plan offered in the State of Oklahoma, which provides medical and surgical benefits, to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition, the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law.

The Prostate Cancer Protection Act, an Oklahoma state law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law provides that all health benefit plans offered by OMES HCM and OMES EGID shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including but not limited to impotence and incontinence, and for other prostate-related conditions.

Once you become covered under a group health plan, you have certain rights under the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you can contact OMES HCM or OMES EGID.

You may also have rights under the Uniformed Services Employment and Reemployment Rights Act. USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. Refer to your agency for more information.

CONTACT INFORMATION

HEALTH PLANS

BCBSOK – BlueLincs
855-609-5684
bcbsok.com/state

CommunityCare
918-594-5242 or 800-777-4890
TDD 800-722-0353
state.ccok.com

GlobalHealth Inc.
405-280-5600 or 877-280-5600
TTY 711
GlobalHealth.com/oklahoma/mystateplan

HealthChoice

Medical
800-323-4314
TTY 711
HealthChoiceOK.com

Pharmacy
877-720-9375
TTY 711
Caremark.com

LIFE INSURANCE

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

ADDITIONAL

EGID
405-717-8780 or 800-752-9475
TTY 711
Oklahoma.gov/omes

American Fidelity Health Services Administration
800-662-1113
afhsa.com

Employee Benefits Department
405-522-5528
Fax 405-521-6308
HCMBenefitsFlexReps@omes.ok.gov
myworkday.com/wday/authgwy/okgov/login

DENTAL PLANS

BCBSOK – BlueCare
855-609-5684
bcbsok.com/state/dental

Cigna Prepaid Dental
800-244-6224
Hearing-impaired relay 800-654-5988
view.ceros.com/cigna/ok-ins-benefits

Delta Dental
405-607-2100 or 800-522-0188
DeltaDentalOK.org/client/OK

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

MetLife
855-676-9443
metlife.com/oklahoma

Sun Life
800-442-7742
onboard.sunlifeconnect.com

VISION PLANS

Primary Vision Care Services (PVCS)
888-357-6912 or TDD 800-722-0353
pvcs-usa.com/okstate

Superior Vision
844-549-2603 or TDD 916-852-2382
superiorvision.com/stateofoklahoma/benefits

Vision Care Direct
855-918-2020 or TTY 711
okstate.vision

VSP
800-877-7195 or TDD 800-428-4833
stateofok.vspforme.com

OKLAHOMA
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& Enterprise Services